



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
ARLINGTON, TX 76013

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-1662-01

MFDR Date Received

MARCH 01, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by South Texas Health System to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine to be the correct amount for this inpatient surgery per the Texas fee schedule in effect as of 2008.

Per the applicable Texas fee schedule the correct allowable would be per the DRG 552. The allowable for this DRG per Medicare is \$6783.03, we have also attached the print out for your review from the Medicare price program. The correct allowable would be at 143% making the allowable at \$9699.82. Based on your payment of \$2939.00, there is an additional of \$6760.82, still due at this time."

Amount in Dispute: \$6,760.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical fee dispute concerns reimbursement for medical treatment the requestor provided to the claimant on September 18, 2012. The requestor billed \$3852.00 for the services rendered, and submits it is entitled to reimbursement in the amount of \$9699.82. The carrier initially approved reimbursement in the amount of \$2939.00 on December 5, 2012 and approved an additional \$913.00 in reimbursement on January 19, 2013. The carrier submits that the total reimbursement amount of \$3852.00 (\$2939.00+\$913.00) is consistent with the applicable fee guidelines. No additional reimbursement is due."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2012	Inpatient Hospital Surgical Services	\$6,6760.82	\$5,847.83

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 *Texas Register* 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated October 11, 2012
 - 29 – The time limit for filing has expired
 - W1 – Workers compensation state fee schedule adjustment
 - 191 – Claim denied because this is not a work related injury/illness and thus not the liability of the workers compensation carrier
 - 535 – No allowance recommended for this report as the report was not submitted in a timely manner per OMFS instructions
 - Claim is denied. No payment will be made

Explanation of benefits dated November 02, 2012

- W1 – Workers Compensation State Fee Schedule Adjustment
- 247 – A payment or denial has already been recommended for this service
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- D1 – Duplicate Control Number 14323

Explanation of benefits dated December 04, 2012

- 193 – Original payment decision is being maintained. This claim was processed properly the first time
- W3 – Additional payment on appeal/reconsideration
- QA – The amount adjusted is due to the bundling or unbundling of services

Explanation of benefits dated January 19, 2013

- W1 – Workers Compensation State Fee Schedule Adjustment
- 947-R03 – Upheld – No additional allowance has been recommended
- 948-R04 – Re-reviewed at providers request with additional information and documentation – additional payment suggested

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Carrier denied services with reason code 191 – “Claim denied because this is not a work related injury/illness and thus not the liability of the workers compensation carrier.” Review of system notes finds no PLN-1 filed by the carrier. Denial code was not maintained in the request for reconsideration. Therefore, denial code is not supported.
2. 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

3. §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

4. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 552, and that the services were provided at South Texas Health System. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$6,783.10. This amount multiplied by 143% results in a MAR of \$9,699.83.
5. The division concludes that the total allowable reimbursement for the services in dispute is \$9,699.83. The respondent issued payment in the amount of \$3,852.00. Based upon the documentation submitted, additional reimbursement in the amount of \$5,847.83 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$5,847.83 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	8/30/13 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-481.